Medsger *et al.* (1971) found, in 309 patients, that male sex and age over 45 are poor prognostic factors at time of diagnosis, and involvement of heart, lung or kidney makes the outlook worse.

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Calcinosis in Scleroderma

J N Rosenberg MB MRCP
(for J G Lewis MD FRCP)
(*Edgware General Hospital, Edgware, Middlesex*)

E M, woman aged 65
History: Raynaud's phenomenon and discharging finger ulcers of two years' duration. No dysphagia.
On examination: Telangiectasia of face and hands. Acrosclerosis with ulceration and pulp atrophy of fingers. Chalky material extruded from some ulcers; mass palpable in left axilla.
Investigations: ESR, serum urea, immunoglobulins, calcium, phosphorus and alkaline phosphatase – all normal. Serology for rheumatoid factor and antinuclear antibodies negative. ECG and chest X-ray normal. Calcinosis noted in left axilla and on X-ray of hands and feet. Barium swallow; œsophageal dilatation and diminished peristaltic activity.

No therapy was advised as hand function remains normal.

Discussion
Patients with calcinosis, Raynaud's phenomenon, sclerodermatous skin and telangiectasia (CRST syndrome) are usually female and may have a benign course (Frayha *et al.* 1973).

Hydroxyapatite is the major constituent of calcinosis, which is thought to be secondary to tissue disturbances as concentrations of calcium and phosphorus ions in serum are normal. Subcutaneous calcinosis may be widespread with minimal overlying skin change. It occurs particularly at pressure points; visceral involvement is uncommon.

Treatment should be advised if symptoms are prominent. Probenecid (Dent & Stamp 1972), aluminium hydroxide (Hudson & Jones 1974) or diphosphonates (Rabens & Bethune 1975) have been advocated. They influence phosphorus metabolism, which has a key role in both normal and abnormal calcification. Probenecid is possibly the drug of choice, being well tolerated and relatively nontoxic. There is no specific drug therapy for scleroderma but D-penicillamine appears promising in active disease (Herbert *et al.* 1974). Reconstructive hand surgery has a place (Entin & Wilkinson 1973), but sympathectomy is of doubtful value for severe Raynaud's phenomenon (Birnstingl 1968).

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Menetrier's Disease and Carcinoma of Stomach

J D Stamatakis[1] BSC FRCS
(for A P Wyatt FRCS)
(*Brook General Hospital, London SE18*)

Miss G K, aged 60
This previously fit woman presented with lethargy of a few months' duration. She was pale, without other abnormal physical signs.
Investigations: Hb 7 g/100 ml, blood film compatible with iron deficiency. Liver function tests and serum proteins normal. Barium meal: large filling defect in fundus and body of stomach, smaller filling defects in antrum.
Operation: A large carcinoma of the fundus of the stomach was confirmed, without macroscopic spread to glands or other organs. A radical total gastrectomy was performed by the thoracoabdominal route, gastrointestinal continuity being restored by a Roux-en-Y anastomosis using proximal jejunum. Postoperative course was uneventful and she was discharged from hospital on the 14th day, able to take a full diet with the usual supplements.

[1]Present address: Department of Surgery, King's College Hospital, London SE5 8RX

Pathology: On opening the specimen the most striking features, apart from the large growth, were the very large folds of gastric mucosa which in many places bore polyps up to 1 cm in diameter. Microscopically the tumour was a well-differentiated adenocarcinoma, not extending through to the serosa, and the resected glands were not involved with tumour. Sections from the folds and polyps away from the growth showed benign epithelial hyperplasia with organized, but very long, gastric glands down to muscularis mucosa, and associated cystic changes. The glands were lined with mucus-secreting epithelial cells and there was a paucity of peptic and oxyntic cells. These features are identical to those described by Menetrier (1888) in his account of gastric polyposis, which in the form of 'polyadénomes en nappe' (sheet of polyadenomas) is now generally called Menetrier's disease.

Discussion

The co-existence of Menetrier's disease and carcinoma of the stomach is rare, but the two conditions do seem to have been associated on several occasions. There are 4 cases reported in which men over 60 known to be suffering from Menetrier's disease were followed for 5 to 13 years before the onset of malignant change was observed (Matzner *et al.* 1951, Texter *et al.* 1953, Lowenthal *et al.* 1960, Chusid *et al.* 1964). It is of particular interest that in 3 of these cases there was transition from large folds to polypoid changes and then the development of cancer. Steigmann *et al.* (1957) recorded 12 cases of Menetrier's disease in detail. Of these, 9 showed simple folds with no polyps but the remaining 3 all showed polyps upon the folds, and 2 of these were associated with gastric carcinoma. Palumbo *et al.* (1951), in a full clinicopathological description, recorded 3 cases of Menetrier's disease, all of which had polypoid changes. In 2 the gastric glands showed invasion through the muscularis mucosæ to the submucosa, and in one of these frank carcinomatous change had taken place. Our case also showed mucosal polyps upon giant gastric folds of the type described by Menetrier, with adenocarcinoma in close juxtaposition.

We conclude that change in the macroscopic form of the mucosa to polyps upon the folds may indicate the development of cellular activity which then proceeds to frank carcinoma. On the basis of available evidence it would seem prudent to adopt a policy of regular gastroscopic surveillance in cases of Menetrier's disease when there are not already sufficient indications for total gastrectomy for the more commonly recognized complications of pain, hypoproteinæmia or bleeding.

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Severe Intra-abdominal Sepsis

C H Browne[1] MB MRCP and
E Gross[2] FRCS
(for Gillian C Hanson MB MRCP)
(*Whipps Cross Hospital, London E11*)

Mrs L F, aged 19

Presented with signs of generalized peritonitis at 36th week of pregnancy. Laparotomy confirmed a ruptured dermoid cyst of the right ovary. On the second day after operation she had a pulmonary embolism and on the ninth day she went into labour and was delivered of a live infant by Cæsarean section. Four weeks after delivery fæces were coming from the abdominal wound, the vagina and a drainage wound in the right iliac fossa. She was transferred to the intensive therapy unit at Whipps Cross Hospital, where hysterectomy was carried out for the infection, with drainage of pelvic and paracæcal abscesses; an opening in the cæcal wall was converted into a cæcostomy.

Consumption coagulopathy followed this third abdominal operation in thirty-nine days. The torrential bleeding required 17 units of whole blood, with platelets, fresh frozen plasma and plasma protein fraction, in twelve hours; heparin was also given. Intravenous feeding was resumed and she required a tracheostomy and intermittent positive pressure ventilation for three weeks.

Further deterioration with purulent discharge from the wound and vagina was noted two weeks after the hysterectomy, and Gastrografin demonstrated a leak at the jejunoileal junction. A second laparotomy revealed widespread peritonitis with perforations of the cæcum and terminal ileum and a large abscess in the left paracolic gutter. The terminal 38 cm of the ileum were removed, and a right hemicolectomy was performed (Mr S G Nardell).

[1]Present address: Brompton Hospital, London SW3
[2]Present address: Hope Hospital, Salford